**** NOTE: Hearing results should be submitted on the Newborn Screening Filter Card OR carbon form Use this form ONLY if these are not available & fax to Newborn Screening Program at 615-532-8555****

Tennessee Department of Health
Newborn Screening Follow Up Program
1st Floor, R.S. Gass Building
630 Hart Lane, Nashville, Tennessee 37243
Phone (855) 202-1357 Fax (615) 532-8555

Hearing Screen Only Form
(See note above – Filter Card or Carbon Copy Form should be used first if possible)

_____

Child's Last Name First Name Middle Name Gender (Twin: A or B) Date of Birth

_____

Birth Mother's Last Name First Name Maiden Name **State Lab TDH#**

_____

Address City State/Zip Phone

_____

Primary Care Provider Phone

Birth Hospital Name: _____ City/State: _____

If this infant was TRANSFERRED, list hospital: _____

Person filling out form (print name): _____ Phone: _____

Facility/Provider Name: _____ City: _____

RESULTS – INITIAL SCREEN:

Date of Initial Hearing Screen: _____/_____/_____ **Method:** ☐ABR/AABR ☐OAE

Results: **R**: ☐Pass ☐Refer **L:** ☐Pass ☐Refer **Risk Factors:** Mark in box at bottom

IF INFANT DID NOT PASS INITIAL SCREEN AND FURTHER EVALUATION (RESCREEN OR DIAGNOSTIC) WAS DONE:

Test done by: ☐Hospital ☐PCP ☐Audiologist ☐ENT/Otolary ☐Other_____

Type of Evaluation: ☐ABR/AABR ☐OAE ☐Tymp/Reflex ☐ASSR ☐Behavioral

Results: **R**: ☐Pass ☐Refer **L:** ☐Pass ☐Refer

IF THIS INFANT WAS REFERRED TO: ☐Audiologist ☐ ENT ☐Other_____

Name: _____ Phone: _____ Appointment on: ____/____/____

Comments/Reason: _____

Risk Factors: (see below, check all that apply)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ A ☐ C ☐ D ☐ F

1. **NICU >5 Days**
2. **Syndrome associated with progressive or late onset HL**
3. **Family History of permanent childhood hearing loss**
4. **Birth conditions or findings including microtia/atresia, ear dysplasia, cleft lip and/or palate, temporal bone abnormalities, white forelock, microphthalmia, congenital microcephaly, congenital or acquired hydrocephalus.**
5. **In-utero infections, such as CMV, Herpes, Rubella, Syphilis and Toxoplasmosis; Zika + Infant**
6. **ECMO**
7. **Asphyxia or Hypoxic Encephalopathy**

A. Events associated with hearing loss including significant head trauma, (especially basal skull/temporal bone fractures) or chemotherapy

C. Aminoglycoside administration >5 days

D. Hyperbilirubinemia requiring exchange transfusion

F. Postnatal culture-positive infections associated with Sensorineural Hearing Loss, including confirmed bacterial and viral (especially Herpes virus and Varicella) meningitis and encephalitis.